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ABSTRACT

Although alcoholism is increasingly recognized as a family disease, most research looks solely at the alcoholic, or occasionally at the alcoholic's spouse. However, there are a multitude of potential studies regarding the alcoholic family system, parent-child communication, marital communication, and sibling communication in the alcoholic home. To initiate efforts to theorize about communication patterns in alcoholic families, a study focused on alcoholism as a source of family stress, and specifically, on the quality of a family's communication. Five family inventories from D. H. Olson, H. I. McCubbin, H. L. Barnes, and A. S. Larsen's 1985 publication, "Family Inventories," were used (administered by a therapist) to survey 6 treatment families and 16 control families at an urban treatment center. Olson's research is based on the Circumplex Model, a model which integrates family concepts and identifies types of marital and family systems within a systemic framework. Although the study sample was too small to achieve statistically significant results, findings do suggest that treatment improves family communication and cohesion, but that there is little or no change in family adaptability. Future studies are needed to replicate this study and to address other questions in family communication which deal with treatment effectiveness, so that a more long-lasting method for eliminating active alcoholism as a source of family stress can be provided. (Contains 1 table of data and 61 references.) (PA)

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COMMUNICATION IN THE ALCOHOLIC FAMILY:

A SUMMARY OF A CASE STUDY

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ABSTRACT
COMMUNICATION PATTERNS IN THE ALCOHOLIC FAMILY:
A SUMMARY OF A CASE STUDY
Dr. Jeanne Cook

This paper focuses on issues of communication in families where one or more of the members are alcoholics or are otherwise chemically dependent. Broader issues of dysfunctional family communication are also addressed. A brief summary of the existing literature linking alcoholism and other chemical dependencies with dysfunction in families is included, followed by a summary of a study of the communication in alcoholic and chemically dependent families during and after chemical dependency treatment.

COMMUNICATION PATTERNS IN THE ALCOHOLIC FAMILY:
A SUMMARY OF A CASE STUDY

Most communication professionals have been ingrained with the notion that knowing more rather than less about communication improves the quality of one's life and the lives of others. This is the ideology of a helping profession: communication researchers believe that what is discovered about the communication process benefits others. Why, then, have we virtually ignored the alcoholic family as a valuable area of study within our discipline? A recent estimate (Iggers, 1990) puts the number of alcoholics in this country at twenty million, including recovering alcoholics. Iggers claims that multiple addictions are common as well. According to the February 26, 1986, issue of the New York Times, there are currently twenty-eight million children of alcoholics in this country alone, six million of whom are minors. Ruben (1992) asserts that ten percent of all people in the United States grew up in an alcoholic family. One-fifth of all Americans are considered to be problem drinkers, and for every alcoholic there are five or six people related by family or work who are directly affected (Hecht, 1973). Iggers (1990) reports the number of codependent people at forty million.

What implications do these staggering numbers have for communication studies? Although alcoholism is increasingly recognized as a family disease, most research looks solely at the alcoholic, or occasionally at the alcoholic's spouse (Nardi, 1981). Certainly there are a multitude of potential studies

regarding the alcoholic family system, parent-child communication, marital communication, and sibling communication in the alcoholic home. Erekson & Perkins (1989) summarize many of the theoretical arguments for studying alcoholic families as systems by pointing out the importance of all subsystems within the family unit (e.g., spouses, siblings, the parental subsystem) in system-wide health. Mackensen and Cottone's (1992) review of the literature focusing on family structure and chemical dependency reflects a growing interest examining connections between subsystem functioning and overall family functioning. Yet in an extensive review of the last several decades of alcoholic family research (Jacob, 1992), attention to communication variables has been marginal at best. Although studies do exist in health, psychological, and family research which examine spouse and family communication in the alcoholic environment, there is virtually nothing in the communication discipline with meaningfully addresses any of the aforementioned issues. Exceptions are Balmert's work on repeaters (1987; 1989), Cook's work on the communication characteristics of adult children of alcoholics (1988a; 1988b; 1987), and a dozen unpublished dissertations in and outside of our field, five of which focus on spouse interaction.

This study examines alcoholism as a source of stress on the family system and, specifically, on the quality of a family's communication. Although the alcoholic's behavior may emerge as predictable over an extended period of time, the consequences of

alcoholism on the family system are not predictable in the eyes of family members. In fact, the family frequently fails to identify one member's alcohol abuse as a source of family stress, but rather identify their individual responses to the alcoholic's drinking as pivotal in controlling stress levels in the family (Ackerman, 1966; Deutsch, 1982; Easley & Epstein, 1991; Fox, 1968; Klagsbrun & Davis; Schwartzman, 1985; Steinglass, Tislenko, & Reiss, 1985).

The goal of this study is to initiate efforts to theorize about communication patterns in alcoholic families. This researcher chose to focus on clinical intervention and family communication patterns. Specifically, can meaningful changes in communication patterns be observed after a family participates in a family-oriented alcoholism treatment program?

It has been suggested that family stress (also referred to as crisis) is determined by a family's ability or inability to deal with sudden or decisive changes (Hill, 1949; Hansen & Johnson, 1979). The literature also suggests that alcoholism is a source of family stress in that alcoholic families are reported as having higher levels of stress and conflict than nonalcoholic families (Barry & Fleming, 1990; Cork, 1969; Jacob, Favorini, Meisel, & Anderson, 1978; Priest, 1985; Wilson & Orford, 1978). Many argue that alcoholic families actually overadapt to the alcoholic's behavior, eventually stagnating the family system by losing their ability for growth and change. Thus, by adapting to the alcoholic's behavior, the family gains a superficial

stability (i.e., they believe they have relieved the stress), but at the cost of a stagnant family system, which likely intensifies family stress over time (Ackerman, 1966; Deutsch, 1982; Fox, 1968; Glasser & Glasser, 1970; Klagsbrun & Davis, 1977; Levine, 1985; Melito, 1985; Morse, Martin, Swenson, & Niven, 1984; Napier & Whitaker, 1978; Schwartzman, 1985; Steinglass, Tislenko, & Reiss, 1985; Wilson & Orford, 1978). Clinical treatment has traditionally been viewed as a means to alleviate active alcoholism as a source of family stress by removing the active alcoholism and assisting the family in reorganizing itself, thereby allowing the family to achieve some level of healthy functioning (Galvin & Brommel, 1982).

Although treatment philosophies are moving from an individual-orientation to a family systems orientation (Balachandvan, 1985; Barnard, 1981; Bateson, 1970; Bowen, 1966; 1976; Harwin, 1982; Janzen, 1977; Litman, 1974; Nace, Dephoure, Goldberg, & Ćommarota, 1982; Nathan & Skinstad, 1987; Schmidt, 1978; Steinglass, 1982), the underlying assumption that removing active alcoholism from the family as being primary to family health has remained constant. This study seeks to explore the validity of this assumption in terms of family communication. That is, as one source of family stress is relieved (active alcoholism), do family communication patterns reflect a lessening of family stress?

It must be acknowledged that the absence of alcohol abuse and its related behavior may actually activate other sources of

stress in the family system; i.e. the family can no longer blame all their problems on one member's alcoholism (Berger, 1983; Dulfano, 1985; Glick & Spencer, 1985; Janzen, 1977). However stress is experienced in the family system, an examination of a family's communication patterns should be revealing regarding source(s) of stress and response to stress.

Theoretical Framework

Hailed as pioneering and innovative theory construction (Holman & Burr, 1980), the Circumplex Model emerged from various systems-related concepts in the marital and family literature. Olson and his colleagues (1983; 1985) wanted to create a model that would help integrate these family concepts and identify types of marital and family systems within a systemic framework. The Circumplex Model clusters concepts from the family theory and family therapy literature into three core dimensions of family behavior: adaptation, cohesion, and communication. Adaptation is the "ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress" (Olson, McCubbin, Barnes, Larsen, Muxen, & Wilson, 1989, p. 48). Cohesion is the degree to which family members feel connected or separated from their family system (emotional bonding); and communication is the pivotal dimension as it facilitates movement in the other two:

> Positive communication skills (i.e., empathy, reflective listening, supportive comments) enable couples and families to share with each other their changing needs and preferences as they relate to cohesion and adaptability. Negative communication

> skills (i.e., double messages, double binds, criticism) minimize the ability of a couple or family members to share their feelings and, thereby, restrict their movement on these dimensions. (p. 49)

Functional families are conceptualized as possessing balanced levels of adaptability, cohesion, and communication (Olson et al., 1989). Conversely, dysfunctional families lack this balance between the three dimensions. It should be noted that the Circumplex model does not conceptualize functional and dysfunction families in a dichotomous fashion, but rather on an x/y axis of greater or lesser family functioning. Since many, if not most, family researchers have abandoned the concept of a "normal" family (Jackson, 1967; Stachowiak, 1975), this issue was not pursued. Indeed, Stachowiak (1975) suggests that the interesting question in family research is no longer, "What is a normal family?" but instead, "In how many ways is it possible to be an effectively functioning family?" (p. 75). In other words, what are the boundaries of deviation in family systems for too much stress and, ultimately, dysfunction?

Methodology

Permission was obtained to use five of Olson, McCubbin, Barnes, Larsen, and Muxen's (1985) family inventories for measuring family communication, adaptation, and cohesion. Specifically, the Marital Communication, Family Strengths, FACES III (Family Adaptation and Cohesion Evaluation subscales), Family Satisfaction, and Parent-Child Communication (including the open parent-child communication and problems in parent-child

communication subscales) inventories were used in this project. Together these inventories measure all three dimensions of family functioning.

Alcoholic families were anonymously surveyed during clinical treatment at an urban treatment center in a Middle Atlantic city in the spring of 1989. The inventories were administered by the center's family therapist. Each family member was asked to rate their family on each item as it applied to their family before treatment. Three months post-treatment the identical inventories were mailed to each family. All family members of at least twelve years of age were asked to complete the survey in both phases of the study. A control group obtained through local Lutheran churches in the same city were surveyed in the same manner.

After ten months of data collection, the survey sample consisted of six treatment families and sixteen control families. None of the six treatment families contained responses from children, necessitating the removal of the children's portion of the Parent-Child Communication instrument from the results. Information about parent-child communication from the parents' perspective was retained.

It was exceedingly difficult to obtain both first and second phase data from both treatment and control families. Many of the treatment families who completed the first phase survey either moved leaving no forwarding address, outright refused to complete the second phase survey, began "using" again and likely

considered themselves disqualified from the study (although they were never told this), or simply chose not to participate in the second phase for other reasons. It should also be noted that the six treatment families who did complete both phases of data collection were a mixed sample. Two families contained an alcoholic, three had multiple addictions, and one was addicted to valium. Although no clear characteristic differences have yet been found between different types of chemically dependent individuals or their families (Seixas & Youcha, 1986), the fact that this sample is a mixture of dependencies and multi-dependencies may assist others in better comparing these results with future research.

The control families generally completed both phases of the survey once they agreed to participate, but several dozen families refused to participate in the study without giving specific reasons. Several pastors hypothesized that some families saw a survey of their family life as too personal and invasive. Olson et al. (1989) also reported similar difficulties. As Olson explains: "Why some couples and families were willing to volunteer and actually participate and others were unable to participate is still an open question" (p. 270). Boosting participation in similar future studies should be a concern to all family researchers.

Results

Because the sample in this study was too small to achieve statistically significant results, changes in scores must be

viewed solely as trends. By computing mean scores for each individual's responses on each inventory and then computing mean family scores for each inventory, the following trends were noted. Each of the family inventories used in this study have been used in a national survey of 1,026 couples and 412 adolescents (n=2,468) (Olson et al., 1985). The results of each inventory will be reported here in terms of family means for the treatment group, control group, and national group.

First, pre-treatment and control families did evidence different mean scores on all five inventories (Marital Communication, Family Strengths, Family Satisfaction, FACES III (Adaptation and Cohesion subscales), and Parent-Child Communication (and subscales). In all cases the control families had higher mean scores than pre-treatment families. In short, treatment and control families were indeed different at the beginning of this project, with the control families indicating greater satisfaction, cohesion, and adaptability in their families, more confidence in the strengths of their family systems, and control parents rating the quality of their communication with each other and with their children more highly.

Post-treatment family mean scores reflect an improvement on most inventories, the exceptions being Family Adaptation and the Problems in Parent-Child Communication subscale. The improved mean scores either raised treatment family scores to the level of

the control families or close to the control families' scores (see Table 1).

Table 1. Mean Family Scores

	Treatment Families		Control Families	
	Phase I	Phase II	Phase I	Phase II
Family Strengths				
Results	35.8	43.0	46.3	47.0
National Norms	46.2	46.2	46.2	46.2
Family Satisfaction				
Results	33.9	45.7	48.1	47.9
National Norms	47.0	47.0	47.0	47.0
Family Cohesion				
Results	32.6	40.5	38.0	36.7
National Norms	37.1	37.1	37.1	37.1
Family Adaptation				
Results	21.8	21.2	24.5	26.1
National Norms	24.3	24.3	24.3	24.3
Parent-Child Communication				
Results	65.3	65.8	78.3	77.3
National Norms	74.0	74.0	74.0	74.0
Open Parent-Child Communication				
Results	35.8	36.3	38.8	38.9
National Norms	38.3	38.3	38.3	38.3
Problems in Parent-Child Communication				
Results	29.5	29.5	39.5	38.4
National Norms	36.0	36.0	36.0	36.0
Marital Communication				
Results	25.8	31.5	36.2	35.9
National Norms	28.1	28.1	28.1	28.1

The fact that treatment families scored above national norms on several inventories (Marital Communication and the family

cohesion portion of FACES III), but not on all inventories, suggests again the post-treatment improvements are occurring, but not uniformly across all three dimensions of family functioning. How significant these improvements are and how typical the lack of uniformity of improvement is can only be determined by follow-up research.

The Marital Communication inventory measures an individual's beliefs, attitudes, and feelings regarding the communication in her/his marital relationship. Questions on this inventory examine the degree of comfort each partner has in sharing feelings and beliefs, perceptions about giving and receiving information, and perceptions of communication effectiveness with her/his partner. Treatment couples were significantly more positive about their marital communication three months after treatment, with post-treatment scores exceeding national norms.

The Family Strengths inventory measures a family's ability to withstand stress. Treatment families were significantly more positive about their families' strengths in post-treatment data collection; i.e. they saw themselves as stronger than three months earlier in terms of family pride, respect, trust, loyalty, optimism, more cohesive in terms of shared values, and stronger in terms of their perceived ability to be able to cope with a variety of situations (Olson et al., 1985).

Several factors may account for this positive change. First, removal of active alcoholism from the family system would immediately change the "appearance" of the family. That is,

family members no longer see drunken behavior from the alcoholic, which in itself would call for reorganization of family perceptions (Callan & Jackson, 1986). Second, post-treatment families should experience less stress (Callan & Jackson, 1986; Filstead, McElfresh, & Anderson, 1981), thus rating themselves more highly on this measure. Third, heightened feelings of cohesiveness generally result in less conflict and critical or hostile interactions (Orford, 1980), concepts which this inventory measures. Fourth, the family therapist at the treatment center used in this study explained that family members often assume they will feel more positively about their family after treatment because they associate all that is negative within the family with the alcoholic's drinking. Whether family members find genuine improvements in the family life three months after treatment, or whether they are experiencing a "honeymoon" phase cannot be determined with the limited information from this study.

Treatment families also reported their level of family satisfaction more highly after treatment. This is congruent with other reports of recovering families, such as Callan & Jackson's subjects (1986) rating their families as "happier" and Cork's child subjects (1969) describing their recovering families as having more fun together. The Family Satisfaction inventory also measure consistency of roles, which Hecht (1973) describes as critical to family members' emotional health. Hecht notes that inconsistent expectations are characteristic of alcoholic

parents. Thus, treatment should result in less inconsistency in roles and rules, which is what treatment families in this study reported.

Finally, treatment parents indicated less satisfaction with their communication with their children than did the control parents. There was, however, some improvement in these perceptions after three months. Treatment parents indicated more open communication with their children and slightly better parent-child communication in general. There was no change, however, in perceptions of problems in parent-child communication; this mean score remained constant in post-treatment and below national norms and control families' scores. Still, the general trend for parent-child communication was one of improvement.

The results of this study do indicate improvements in treatment family communication and cohesion, but little or no change in family adaptability. It could be that family adaptability is the most difficult and time consuming dimension in the family system to change. But one cannot overlook the possibility that this study's results may indicate a problem with the Circumplex Model. Future studies are needed to replicate and extend this project before any firm conclusions can be drawn. What can be concluded with relative certainty is the existence of positive changes in the family system three months after treatment--changes not reflected in the control group. It appears that something about the treatment these patients and

their families received is working. The difficulty here is that treatment programs cannot pinpoint exactly what they are doing that provides particular results. It is not that treatment programs lack a treatment philosophy, but a theory of treatment (Morse, 1988).

Is it possible, for example, that all the results of this study could be attributed simply to the sobriety of the alcoholic? Is cessation of drinking alone catalyst enough for the positive changes evidenced here? Although cessation of drinking is vital for the reorganization of the alcoholic family system, the literature is increasingly firm in responding to this question in the negative. Whether the results of this study can be attributed specifically to the family-oriented nature of this urban treatment center can only be determined by future comparisons with other programs. In short, follow-up research of this project is critical to answering with confidence any of the important questions raised in this study.

Directions for Future Research

Although the results of this study appear to support the notion of communication as a critical function in family systems, particularly in relieving or compounding family stress brought on by active alcoholism, further research is clearly needed in order to competently theorize about the relationship between communication quality and family stress. First, validation studies which include a third time lag phase are needed. It is

important to discover not only if the results of this study are typical, but if the communication and stress level changes among families undergoing alcoholism treatment found here reverse themselves, remain the same, or continue to improve over time. One such study (Preli, Protinsky, & Cross, 1990) examined the three core dimension of the Circumplex Model in alcoholic families one full year after sobriety was achieved and found continued improvement in each dimension; however, family dysfunction was not completely absent. More studies are needed to test these results and to examine even longer term effects.

Second, it will be important to compare types of treatment within and between treatment centers. For example, is the inpatient program at the treatment center used in this study more or less effective in positively influencing family communication patterns than the outpatient program? Do programs for alcoholics and other types of dependencies differ? Is their effectiveness different? Is the treatment center used in this study more or less effective than other treatment programs with a family treatment component? Until these questions are addressed in family communication research, there can be no communication theory of treatment effectiveness.

This study provides preliminary evidence that meaningful changes in communication patterns can be observed after a family participates in a family-oriented alcoholism treatment program. Considering the widespread presence of alcoholic families in our culture, it behooves our field to pay greater attention to this

special population. The more we can learn about communication in alcoholic families, the better we can assist treatment centers in improving the communication component in their family programs and, in turn, provide a more long-lasting method for eliminating active alcoholism as a source of family stress.

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